PRINTED: 08/16/2011
FORM APPROVED
OMP NO. 0038 0301

	R MEDICARE & MEDIC						IB NO. 0938-0391
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED		
15E245		B. WIN		07/22/2011			
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					EST 86TH STREET		
ST ALICI	JSTINE HOME FOI	P THE AGED			APOLIS, IN46260		
STAUGU	JOTINE HOME FOR	R THE AGED		INDIAN	APOLIS, IN40200		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Post Survey R	Revisit (PSR) to the Life	K	0000			
	1	certification and State					
	1 *	ey conducted on 05/23/11					
		-					
		by the Indiana State					
	_	Health in accordance with					
	42 CFR 483.70((a).					
	Survey Date: 07/22/11						
	Facility Number: 000389						
	1 -						
	Provider Number: 15E245						
	AIM Number: 1	100288920					
	Surveyor: Mark Caraher, Life Safety						
	Code Specialist						
	1						
	At this DCD curs	yay St Augustina Homa					
	At this PSR survey, St. Augustine Home						
	_	s found not in compliance					
	with Requirements for Participation in						
	Medicare/Medicaid, 42 CFR Subpart						
	483.70(a), Life S	Safety from Fire and the					
	` ′ ′	the National Fire					
	Protection Association (NFPA) 101, Life						
	I - '	SC), Chapter 19, Existing					
		cupancies and 410 IAC					
	16.2.						
	This facility loc	cated on the second and					
	third floor of a three story building was						
		e of Type II (222)					
	construction and	I fully sprinklered. The					
	facility has a fire	e alarm system with					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XM4G22

Facility ID:

000389

TITLE

If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED 07/22/2011			
AND FLAN OF CORRECTION		15E245	A. BUILDING	01				
		102210	B. WING	ADDRESS, CITY, STATE, ZIP CODE	0172272011			
NAME OF PROVIDER OR SUPPLIER								
ST AUGL	JSTINE HOME FOR	R THE AGED	2345 WEST 86TH STREET INDIANAPOLIS, IN46260					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
PREFIX TAG			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE			
K0011 SS=E	smoke detection in the corridors and all areas open to the corridor. The facility has a capacity of 42 and had a census of 40 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/25/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating		IAG	DEPICIENCY)	DATE			
	protected by appro 19.1.1.4.1, 19.1.1. Based on observa facility failed to a the fire barrier se the assisted living protection needed barrier. LSC 19. LSC 8.2.3.2.3.1 In hour fire barrier I having at least a rating. This defice residents, staff ar	ation and interview, the ensure 4 of 4 door sets in eparating health care from g occupancy provided the d for a two hour fire 1.1.4.2 refers to LSC 8.2. requires openings in a 2 be provided with doors 1 1/2 hour fire protection cient practice could affect and visitors in the vicinity d third floor dining room access doors and the	K0011	We are enclosing a copy of a contract that we have with Koorsen's Fire and Security the shows it is the Corporate Boardecision to put smoke detection all areas eliminating the new for fire barrier doors since this would then enlarge the area having the exterior doors as fire exits. The following smoke detectors have been installed far: 3 smoke detectors in the East Dining Area and 2 in the East Dining area. The corridor outside the 2 East has 4 smodectectors and the corridor of	that ard's ors eed s the te d so e 2 e 3 or			

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lity ID: 000389

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	LE CO	NSTRUCTION 01	(X3) DATE COMPL			
15E245		A. BUILDING	j		07/22/2			
		-	B. WING _	SEET V	DDRESS, CITY, STATE, ZIP CODE	L		
NAME OF PROVIDER OR SUPPLIER			2345 WEST 86TH STREET					
ST AUGUSTINE HOME FOR THE AGED			INDIANAPOLIS, IN46260					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TA	- 1	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ΓE	COMPLETION DATE	
1/10		floor West Corridor door	177		East has 4 smoke Detectors	in	DATE	
	sets.	moor west corridor door			the corridor. All of these smo			
	50.5.				dectectors are connected to	he		
	Findings include	:			Fire Panel.			
	C							
	Based on observa	ations with the						
	Maintenance Ma	nager during a tour of the						
	facility from 11:0	00 a.m. to 11:50 a.m. on						
	07/22/11, the sec	ond and third floor						
	_	ter Stairwell access door						
		nd and third floor West						
		ts in the fire barrier						
		care from assisted living						
	-	lay the one and one half						
		red for a door in a two						
		on, the Maintenance						
		rledged no fire protection						
	-	on each door and they						
	_	documentation of the fire						
	protection rating							
	This deficiency v	was cited on 05/23/11.						
	The facility faile	d to implement a						
	systemic plan of	correction to prevent						
	recurrence.							
	3.1-19(b)							

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E245	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE : COMPL 07/22/2	ETED
NAME OF PROVIDER OR SUPPLIER ST AUGUSTINE HOME FOR THE AGED		•	2345 W	DDRESS, CITY, STATE, ZIP CODE EST 86TH STREET APOLIS, IN46260			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0018 SS=E	than required enclexits, or hazardous doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with a keeping the door of meeting 19.3.6.3.6 Roller latches are regulations in all h Based on observation facility failed to rooms' corridor of positive latching practice could affivisitor in the vicidining room and room. Findings include Based on observation facility from 11:007/22/11, the section has two sets of countries and the countries are regulations in all heads of the countries of the		KO	0018	We consulted with Beth A. Alexander from FP&C Consultants at 486-5188 whe explained that since we were putting smoke detectors in eroom in the home that the doare not connected with Fire Barrier.	e very	08/11/2011

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE S	3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED		
 •		15E245	B. WING			07/22/2	011
NAME OF PROVIDER OR SUPPLIER ST AUGUSTINE HOME FOR THE AGED		STREET ADDRESS, CITY, STATE, ZIP CODE 2345 WEST 86TH STREET INDIANAPOLIS, IN46260					
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	O TO THE APPROPRIATE	
K0044 SS=E	Manager acknown door set was not latching hardwar. This deficiency of the facility failed systemic plan of recurrence. 3.1-19(b) Horizontal exits, if with 7.2.4. 19.2. Based on observer facility failed to the fire barrier set the assisted living equipped with potential points. LSC 19. exits to be in accompanies. LSC 19. exits to be in accompanies. LSC 8.2.3.2.1 reconstalled in accompanies. LSC 8.2.3.2.1 reconstalled in accompanies. In accompanies with the protection of th	used, are in accordance 2.5 ation and interview, the ensure 4 of 4 door sets in eparating health care from g occupancy are ositive latching to provide eded for a two hour fire 2.2.5 requires horizontal ordance with 7.2.4. LSC is any opening in fire eted as provided in 8.2.3. quires fire doors to be redance with NFPA 80. In 0, Standard for Fire lows at 2-1.4.1 requires all sms shall be adjusted to sistance of the latch	K00)44	We are putting in smoke dectectors in every room in the home thus expanding the fact After consultation with Beth Alexander and Mr. Dean Illingworth it is our understanthat their is no separation of nursing from the residential.	cility.	08/11/2011

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STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E245		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 07/22/2011			ETED		
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
ST AUGUSTINE HOME FOR THE AGED				1	'EST 86TH STREET APOLIS, IN46260		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		a door operation. This		TAG	DEFICIENC!)		DATE
		e could affect residents,					
		in the vicinity of the					
		floor dining room Center					
		doors and the second and Corridor door sets.					
	tnird floor west	Corridor door sets.					
	Findings include	::					
	Based on observations with the Maintenance Manager during a tour of the facility from 11:00 a.m. to 11:50 a.m. on						
	07/22/11, the second and third floor dining room Center Stairwell access door sets and the second and third floor West Corridor door sets in the fire barrier						
		a care from assisted living					
		vided with a positive					
		ism. Based on interview					
	at the time of ob	servation, the					
		nnager acknowledged each					
		equipped with a positive					
	latching mechan	ism.					
	This deficiency	was cited on 05/23/11.					
		ed to implement a					
	systemic plan of	correction to prevent					
	recurrence.						
	2 1 10(b)						
	3.1-19(b)						